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BREAKING BAD NEWS TO PATIENTS OR NEXT OF KIN

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Description

The purpose of this study was to gain knowledge about how nurses perceive breaking bad news. The aim was to provide information that can help nurses to convey bad news to patients and their next of kin by providing guidance.

Qualitative research approach was used. Literature provided the basic information about breaking bad news to patients and next of kin and interviews of nurses provide their perspective on the subject. The study was carried out in Central Finland Health Care District (JYTE) in the autumn 2015. In-depth interviews of two nurses who had experience with breaking bad news were conducted. In the interviews semi-structured questions were used. Inductive content analysis was used to analyze the study results in the autumn 2015.

The results indicate that nurses experience breaking bad news as a challenging task that doesn't necessarily get any easier even with experience. The interviewees also experienced support from colleagues as a significant resource in breaking bad news. Nurses in this study felt that it is often more challenging to break bad news to the next of kin than to patients because the next of kin often vent their sadness and anger to the attending staff. The results indicate that little education concerning breaking bad news had been provided for nurses, but such education would be important and desired.

Keywords (subjects)
Breaking bad news, patient, next of kin, interview study, nursing experiences, nursing education

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Tiivistelmä

Tässä tutkimuksessa tutkittiin miten sairaanhoitajat kokevat huonojen uutisten välittämisen potilaalle tai heidän läheisilleen. Tavoitteena oli tarjota tietoa, joka auttaisi sairaanhoitajia puhumaan vaikeista asioista potilaiden ja heidän läheistensä kanssa.

Tutkimuksessa käytettiin kvalitatiivista lähestymistapaa. Kirjallisuus tarjosi taustatiedot vaikeiden asioiden kertomisesta potilaille ja heidän läheisilleen ja haastattelut tarjosivat sairaanhoitajien näkökulman asiaan. Tutkimus toteutettiin Jyväskylän yhteistoiminta-alueen terveyskeskuksessa (JYTE) syksyn 2015 aikana. Kahdelle sairaanhoitajalle, joilla oli kokemusta vaikeiden asioiden kertomisesta, tehtiin syvähaastattelu teemahaastattelun keinoin. Induktiivista sisällön analyysiä käytettiin tutkimuksen tulosten käsittelyyn. Tulokset käsiteltiin vuoden 2015 syksyllä.

Tutkimuksen tulokset viittaavat siihen, että sairaanhoitajat kokevat vaikeiden uutisten kertomisen haastavana tehtävänä, joka ei välttämättä tule helpommaksi kokemuksen myötä. Kollegojen tuen koettiin olevan merkittävä voimavara vaikeiden uutisten kertomisessa. Vaikeiden uutisten kertominen potilaan läheisille koettiin usein vaikeampana kuin itse potilaille, koska läheiset usein purkavat pahaa oloaan hoitohenkilö-kuntaan. Tulokset viittaavat siihen, että vaikeiden asioiden kertomisesta on vähän koulutusta tarjolla sairaanhoitajille, mutta sellainen koulutus olisi tärkeää ja toivottua.

Avainsanat (asiasanat)
Vaikeiden uutisten kertominen, potilas, läheinen, haastattelututkimus, sairaanhoitajien kokemuksia, sairaanhoitajien koulutus

Muut tiedot

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1 Introduction

Information that drastically alters the life of the patient is termed as bad news (Narayanan, Bista, & Koshny 2010). The term 'breaking bad news' is mostly associated with the moment when negative medical information is shared with a patient or relative. But it can also be seen as a process of interactions that take place before, during and after bad news is broken. (Warnock, Tod, Foster, & Soreny 2010.) . Warnock (2014) says that more recently this perspective has been widened, so that it can mean also information which alters peoples' perceptions of their present or future and it can relate to a wide range of topics and circumstances. However well one says it, a bad news is always a bad news. But the manner in which it is conveyed can have a profound effect on both the recipient and the giver. If it is done badly, it can impair patient's quality of life, hamper well being, and also future contact with the health care professionals. (Narayanan, Bista, & Koshny 2010.)

So, breaking bad news is a complex communication task, which affects the patient's satisfaction with care, comprehension and level of hopefulness (Kirk, Kirk, & Kristjanson 2004). Lack of sufficient training in breaking bad news is a handicap to most health care workers and physicians (Narayanan et al. 2010). The task of breaking bad news can be improved by understanding the process involved and approaching it as a stepwise procedure, and also applying well-established principles of communication and counseling (Baile, Buckman, Lenzi, Glober, Beale, & Kudelka 2000).

So the situation where bad news has to be conveyed in a health care situation is not easy for the patient, next of kin or for the one conveying the information. Likely many nurses contemplate how to tell bad news and just gradu-

ated nurses are more likely to have many questions about how to discuss negative news with patients. The aim of this study is to provide information that can help nurses to convey bad news by providing guidance. The purpose of this study is to gain knowledge how nurses perceive breaking bad news.

There is a lot of literature about doctors breaking bad news, for example Arnautska (2009), Baile, Lenzi, and Kudelka (1997), Friedrichsen and Milberg (2006), Kirk et al. (2004) and Naik (2013) have addressed the issue, but there aren't many studies about nurses doing the same. Nurses point of view of breaking bad news have studied by for example Warnock et al. (2010), Warnock (2014) and Rassin, Levy, Schwarz, and Silner (2006), but still there is need for more information about the subject. This study tries to fill this gap, providing also a nurses perspective to breaking bad news. Literature in this thesis will provide the basic information of breaking bad news to patients and next of kin and interviews of nurses will provide their perspective in the subject.

2 Breaking Bad News

2.1 Nursing perspective

Laws and regulations provide the basis of patient education in health care. This means that the law of the status and rights of the patient should be taken into consideration. Patient education must also be carried out with the consent of the patient and in agreement with the patient. (Potilasohjauksen haasteet [Challenges of patient counseling] 2006.) Patient-centeredness is included in all stages of the health care service and patients are treated equally without discrimination. Human and fundamental rights, the patient's personal

integrity, security and privacy, are respected. (Terveydenhuollon laatuopas [Health Care Quality Guide] 2011.)

Also the ethics of health care provides the basis of patient guidance and increases the understanding of an ethically correct way of doing things. The goal is to enhance the patients' health. Also a nurse must be aware of and take responsibility of her actions. (Potilasohjauksen haasteet [Challenges of patient counseling} 2006.)

It is important to take into account that the patient may be in a crisis stage, making his ability to receive guidance less than optimal. A nurse must be able to assess how much the patient can absorb information and according to that estimate the best way of communication. Care staff is required also to be able to assess both the physical and mental state of the patient and on this basis to evaluate how much information and support the next of kin needs. Based on this information the nurse is able to provide information and personalized support, so that the next of kin have better chances of coping with anxiety caused by the disease of a close one. This can also enhance the patients' satisfaction and feeling of safety. (Potilasohjauksen haasteet [Challenges of patient counseling} 2006.)

So interpersonal skills are an important part of carers' skills and therefore, the development of communication skills is important. Successful interaction involves mutual respect, sincere interest in another person, ability to express thoughts clearly, and the ability to ask questions. Also, ability to observe, and listening skills contribute to the success of the interaction. (Potilasohjauksen haasteet [Challenges of patient counseling] 2006.)

2.2 Patient perspective

The patient has the right to receive individual, skilled and friendly care (Terveydenhuollon laatuopas [Health Care Quality Guide] 2011). The care of the patient has to be arranged so and he shall also otherwise be treated so that his human dignity is not violated and that his conviction and privacy is respected. The mother tongue, individual needs and culture of the patient have to be taken into account as far as possible in his care and other treatment. (Act on the status and rights of patients 1992.) So the goal is that the patient can trust that the care staff is well trained and can help him in accordance with current evidence-based information (Terveydenhuollon laatuopas [Health Care Quality Guide] 2011).

A patient shall be given information about his state of health, the significance of the treatment, various alternative forms of treatment and their effects and about other factors related to his treatment that are significant when decisions are made on the treatment given to him. However, this information shall not be given against the will of the patient or when it is obvious that giving the information would cause serious hazard to the life or health of the patient. (Act on the status and rights of patients 1992.)

So the patient should receive enough information about his illness to be able to participate planning in his own care. The goal is that the patient is content with the care and feels that he has received enough help for the health problem. (Terveydenhuollon laatuopas [Health Care Quality Guide] 2011.) Health care professionals should try to give the information in such a way that the patient can understand it. If the health care professional does not know the language used by the patient or if the patient because of a sensory handicap or speech defect cannot be understood, interpretation should be provided if possible. (Act on the status and rights of patients 1992.)

2.3 Ways of delivering bad news

Breaking bad news is nowadays generally accepted as a process, not a one-off event, and it is considered to refer to any bad, sad or difficult information that alters patient's perceptions of his present and future (Warnock 2014). How bad the news is seen to be, will depend on the patient's expectations and in what context the bad news are in that persons' life (Caillier 2010). However, "bad news" is always a subjective experience, so that one cannot estimate the impact of the bad news until one has first determined the recipient's expectations or understanding. Bad news can be for example malignant biopsy, an HIV -positive blood test, a surgical complication, the need for amputation or even impending death (Caillier 2010). Although bad news may be very sad for the patients, the information may be important in allowing them to plan for the future (Baile et al. 2000).

Kirk et al. (2004) qualitative study indicates that the delivery of information and perceived attitude of practitioners are critical to the process. The need for sensitivity and respect for individual wishes in the communication process emerged as a central theme in their study. It is important to recognize that what you are about to tell will change the patients life (Seppänen 2012). According to Buckman (1992) an expert in breaking bad news is not someone who gets it right every time – she or he is merely someone who gets it wrong less often, and who is less flustered when things do not go smoothly.

Informing the family members about the sudden death of their loved one is a highly stressful experience. A health care professional needs a special skill in breaking the bad news to the family. A humane approach from staff of the hospital towards the relatives of the deceased benefits the family and also protects the hospital from potential conflicts surrounding the death of the patient.

(Naik 2013.) But conveying bad news is not at all easy and requires a skilled communication (Narayanan et al. 2010, Warnock 2014).

A patient's dissatisfaction with information is often related to doctor-patient interaction (Kirk et al. 2004). The most common problems are generally caused by relatively simple errors – faults in common courtesy, failures in listening or in acknowledging the patient's needs (Buckman 1992). In the case of malpractices several studies show that patients usually don't want to accuse anyone but they want to know what happened, and they expect an apology (Potilaalle kertominen [Telling the patient] n.d.). If communication is properly structured and well-done, it has a positive therapeutic effect. Physicians often find breaking bad news difficult due to many reasons. They may feel incompetent and are afraid of unleashing a negative reaction from the patient or their relatives. It also reminds of their own vulnerability to terminal illness, and thus they can feel powerless over emotional distress. (Narayanan et al. 2010.)

Telling about procedures and the results of tests is primarily the job of the physician (Pohjois-Pohjanmaan sairaanhoitopiirin hoitoeettinen työryhmä [Northern Ostrobothnia Hospital Care Ethics Working Group] 2010). But also nurses are involved in diverse breaking bad news activities at many points in care pathways (Warnock et al. 2010). Nurses have an important role in the process of providing information and helping patients and relatives prepare for, receive, understand and cope with the bad news they have been given (Warnock 2014). Also Rassin et al. (2006) research indicates that nurses have a crucial role in the process of breaking bad news and in supplying written information for the receiver of the news. Warnock (2014) advises that if a nurse feels she doesn't have the knowledge, expertise or time to respond to concerns raised by patients and relatives, it is essential that she acknowledges the importance of the concerns and also informs patients and relatives that she plans to address them later.

According to Rassin et al. (2006) caregivers do not receive enough training and counseling about breaking bad news, and hence find this task daunting. Becoming more skilled in communication lessens stress and burnout when breaking bad news (Caillier 2010). A study of Baile et al. (2000) showed that teaching breaking bad news is perceived useful, and it increases the sense of competence and ability to formulate a strategy for such situations. The study showed that techniques for disclosing information in a way that addresses the expectations and emotions of the patients also seem to be strongly desired, but are rarely taught. Their study emphasizes a need to teach physicians and nurses to break bad news in a way that would be less stressful both to the patients and the conveyer of bad news. Also Warnock (2014) states that nurses are in an important role in the process of breaking bad news and it should be recognized and supported by guidance and education. This would help the development of nursing skills.

Shannon, Long-Sutehall, and Coombs (2011) study notes that listening and the use of silence are important in end-of-life conversations with critically ill patients and their family members. But often the challenge for nurses is to know how to skilfully explore perceptions, respond to difficult statements and communicate patient or family members' concerns among the health care team. The results of their study affirmed the usefulness of having specific skills to gain additional information from patients and families in challenging conversations. Also a structured format was found useful when sharing information with other members of the health care team.

According to Narayanan et al. (2010) study, an adherence to the principles of client-centered counseling is helpful in attaining the skill of breaking bad news. Fundamental insight of the patient can be exploited and the bad news delivered in a structured manner. Although Buckman (1992) states that much

of the most valuable education in breaking bad news comes, not from didactic teaching or even from good role models, but from patients and their relatives. Their feedback helps and educates us to distinguish adaptive and supportive responses to bad news from unhelpful ones. After all the patient is the one who knows what is hurting him the most and he is the one who knows how to move forward (Narayanan et al. 2010). Efficient methods to teach how to break bad news could be for example conducting workshops, viewing videotaped interactions between clinicians and simulated bereaved relatives, and also small group role-plays (Naik 2013).

Many different kinds of ways to break bad news to patients have been developed. Here will be summarized some examples of them. Baile and others (2000) have created a six step protocol (SPIKES) to breaking bad news. Students who have been taught the SPIKES protocol have reported increased confidence in their ability to disclose unfavourable medical information to patients. The protocol's goal is to enable the clinician to fulfill the four most important objectives of the interview disclosing bad news: gathering information from the patient, transmitting the medical information, providing support to the patient, and eliciting the patient's collaboration in developing a strategy or treatment plan for the future. 'SPIKES' comes from the following words: S- Setting up, P- Perception, I- Invitation, K- Knowledge, E- Emotions and S- Strategy and Summary.

First step of SPIKES is setting up the interview. Mental rehearsal is a good way for preparing for stressful tasks as this. It can be done by reviewing the plan how you are going to tell the news to the patient and how to respond to patient's emotional reactions or difficult questions. Arrange private place for the discussion, have the patient sit down and ask if the patient wants to choose one or two family representatives to come with them. Maintaining eye contact is an important way of establishing rapport, also inform the patient of

any time constraints you may have or interruptions you expect. Next step is assessing the patient's perception, when you assess how the patient perceives his medical situation. Step three is obtaining the patient's 'Invitation'; in this phase you assess what the patient wants to hear. A majority of patients want to hear all information about their diagnosis, prognosis, and details of their illness, but some patients do not. If patient does not want to know details, offer to answer any questions they may have in the future or to talk to a relative or friend. (Baile et al. 2000.)

Step four is giving knowledge and information to the patient. Giving medical facts may be improved by a few simple guidelines. Start at the level of patient's comprehension and vocabulary and avoid excessive bluntness e.g., "You have very bad cancer and unless you get treatment immediately you are going to die." Give information in small pieces and check periodically that the patient understands the information. If the prognosis is poor, avoid using phrases such as "There is nothing more we can do for you." (Baile et al. 2000.)

Fifth step is addressing the patient's emotions with empathic responses. Patient's emotional reactions may vary from silence to disbelief, crying, denial, or anger. To response to these feelings you can move closer to the patient and also touch the patient's arm or hand if you both are comfortable with it. Also pause for a moment to allow the patient to get her composure. Let the patient know that you understand why she is upset by making a statement that reflects your understanding. Before an emotion is cleared, it will be difficult to go on to discuss other issues. If the emotion does not diminish shortly, it is helpful to continue to make empathic responses until the patient becomes calm. You can also acknowledge your own sadness or other emotions by empathic responses; for example stating "I also wish the news were better". (Baile et al. 2000.)

Support can be shown also by a validating statement, which lets the patient know that his feelings are legitimate. If emotions are not clearly expressed, for example when the patient remains silent, you should ask an exploratory question before making an empathic response, for example "Could you tell me what you're worried about?" If emotions are subtle, indirectly expressed or disguised as disappointment or anger: "I guess this means I'll have to suffer through chemotherapy again", you can still use an empathic response, and for example "I can see that this is upsetting news for you". (Baile et al. 2000.)

The final step is forming a strategy and summarize what has been talked about. Before discussing about a treatment plan, it is important to ask the patient if he is ready for such a discussion. If he is ready, make a strategy for the future; if a patient has a clear plan for the future he is less likely to feel anxious or uncertain. (Baile et al. 2000.)

Another six-step protocol, developed by Narayanan et al. (2010), the BREAKS protocol, is also an easy communication strategy for breaking bad news. 'BREAKS' comes from the following words: B –Background, R– Rapport, E – Explore, A –Announce, K–Kindling and S –Summarize. According to their study an effective therapeutic communication starts with the in-depth knowledge of the patient's problem, or background. That follows building a rapport, where one needs to have an unconditional positive regard. A hostile attitude or hurried manner would have a disastrous outcome. If the patient is not prepared for the bad news, especially after getting his symptoms well palliated, let the patient finish the reports of well being, and then try to take cues from the conversation to initiate the process of breaking bad news.

Next step is 'Explore' where the history, the investigations, the difficulties met in the process etc. are explored. Find out what the patient thinks about the disease and diagnosis. Also you can identify if there are conflicts between the

patient's beliefs and diagnosis. Next follows 'Announce'-phase when the diagnosis is being told. The patient has the right to know the diagnosis, but at the same time he has the right to refrain from knowing it. Hence, one has to have consent before announcement of the diagnosis. Information should be given in short, easily comprehensible sentences. The body language of both the physician and patient is very important, and the physician is supposedly a mirror image of the patient. All the patient's feelings (for example embarrassment or fear) should be reflected in the physician who mirrors the patient's emotions, so that the patient would identify the physician as a close one. (Narayanan et al. 2010.)

In 'Kindling' -phase one must give adequate space to the patient so that emotions can freely flow. Make sure that the patient understands the nature of disease, the gravity of situation and the realistic course of disease with or without treatment options. Be careful not to suggest any unrealistic treatment options. At the end of the meeting summarize the session and the concerns expressed by the patient during the session. Also it can be good to find out whether someone at home can provide support. (Narayanan et al. 2010.)

Verbal communication should be based on participatory and encouraging sentences and the use of sentences that have negative approach should be avoided (Rassin et al. 2006). Also Burgers, Beukeboom and Sparks (2012) study showed that positively framed messages have positive effects on patient's evaluations compared to negatively framed messages. Also the use of negations or affirmations makes a difference. Positively framed message was seen more negatively when it contained negations (e.g., "the news is not bad") rather than affirmations ("the news is good"). Negations (e.g., "not bad") caused negative associations, which implied that there may actually be opposite negative expectancy. Caillier (2010) advises that it is better to say" I'm sorry for you" than "I'm sorry". Also you can use key words from the patient's last sen-

tence in your first sentence. For example if the patient says ”I’m disappointed with my treatment,” you might reply ”What aspect of your treatment disappoints you?” The sentence "It'll be alright" was indicated by the patients as very helpful, even though caregivers seldom used it possibly because it is thought to give false hopes in the patient (Rassin et al. 2006).

In Kirk et al. (2004) study, the patients expressed a need for hope even when they knew that they were in the terminal stages of disease and had a limited life expectancy. To have ones’ hope dashed by an insensitive or rushed health carer was experienced as extremely negative. Even in the end stages, patients and families still wanted the door to be left open for the possibility of a miracle. Participants were also distressed when information about prognosis was vague or inaccurate, was presented along with conflicting information, or was given by someone not perceived to be an expert or directly in charge of their care. (Narayanan et al. 2010.)

So there are several accepted methods that teach how to break bad news. Two possible methods are the SPIKES-protocol created by Baile et al. (2000) and the BREAKS protocol by Narayanan et al. (2010). Eggly et al. (2006) claim that health care providers should not be trained to anticipate and engage in scripted encounters such as “the bad news encounter.” This is because we cannot plan for a bad news discussion before it occurs because its interpretation as bad news results from the discussion. According to Seppänen (2012) there isn’t any right or wrong way to break bad news; you can develop your own way that suits your personality. You can for example find new ways to handle difficult communication situations by observing how colleagues handle similar situations. The task of breaking bad news can be improved by understanding the process involved and approaching it as a stepwise procedure, and also applying well-established principles of communication and counselling (Baile et al. 2000).

Rosenzweig (2012) states that the use a template such as the SPIKES Protocol for breaking bad news is good if you are unsure of how to proceed. Often you must complete this task during a busy workday, with a less than optimal conditions and time. Not all communication involving breaking bad news can follow an exact protocol, but these standardized approaches can be a helpful guide when initiating difficult conversations. And also not every episode of breaking bad news will require all of the steps of SPIKES, but when you use them they are meant to follow each other in sequence (Baile et al. 2000). You can also practice speaking phrases in advance and this can give you more confidence to break the bad news (Breaking bad news 2013). You should relate to the breaking bad news as if it were a complicated procedure: the situation would be demanding for everyone (Seppänen 2012).

For the purposes of this study, checklists were done in Finnish and English that summarizes "Breaking bad news" -guidance from literature (Appendix 3.). It was done to make it easier for the nurses to deliver bad news and ensure that the patients would get the best possible care. It provides some points to be considered or can act as a reminder on how to break bad news. So it can be used as a tool in patient encounters. The literature used as a base of the summarized guidance are the SPIKES-protocol created by Baile et al (2000) and the BREAKS -protocol created by Narayanan et al. (2010). These protocols were chosen because they are most commonly cited in "Breaking bad news" -literature.

Also Breaking bad news (2013) describes an ABCDE mnemonic rule that summarizes phases of breaking bad news:

Advance preparation
Build a therapeutic environment/relationship
Communicate well
Deal with patient and family reactions
Encourage and validate emotions

3 Aim and purpose of the study

The aim of this study is to provide information that can help nurses to convey bad news by providing guidance. The purpose of this study is to gain knowledge how nurses perceive breaking bad news. This study tries to answer the following question:

1. What is in a nurse's opinion the best way to break bad news?

4 Methodology

4.1 Sources of information

Literature in this thesis provides the basic information of breaking bad news to patients. Study related literature was searched using the CINAHL-search programme. The search was conducted by searching by the term "Breaking bad news". Search publication dates were restricted to years 2010-2015 and only peer reviewed and full text articles were searched. The search gave 17

article results. These 17 article's titles and abstract were read to determine their relevance and appropriateness for this research. Five articles that were most related to the research subject were chosen and read carefully. Also manual article search was used by selecting articles based on the references-lists of these five articles and also references-lists from other study related articles.

4.2 Research methods

Qualitative health research aims to answer 'what', 'how' or 'why' questions about social aspects of health, illness and health care (Green & Thorogood 2014). The qualitative research method will be used in this study in the form of personal interviews. This method is used because of the qualitative research can be used to gain insight into people's attitudes, behaviours, value systems, concerns, motivations, aspirations, culture or lifestyles. Qualitative research is also good when the study concerns small samples using purposive, convenient or snow ball sampling technique. (Qualitative research in nursing 2013.) According to Pratt (2006) the main methods employed in qualitative research are observation, interviews, and documentary analysis. A great deal of qualitative material comes from talking with people whether it is through formal interviews or casual conversations. In-depth interviews are optimal for collecting data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics are being explored (Qualitative research in nursing 2013).

The study question was considered to be such in nature that a questionnaire would not give participants the chance to express their experiences in full. Interviews were conducted to get more comprehensive picture of the target

populations' experiences of breaking bad news. Therefore, qualitative research was used for this study because of the nature of the study.

4.3 Recruitment of participants

Convenience sampling was used in choosing the target population to this study. Convenience sampling is a non-probability sampling method that relies on data collection from population members who are conveniently available to participate in the study (Convenience sampling 2014).

The research was conducted in Central Finland Health Care District (JYTE), in two health care centers. The interviews were limited only to those nurses who in their work have had to break bad news to patients and already have some experience about it. The term 'breaking bad news' is according to Warnock et al. (2010) mostly associated with the moment when negative medical information is shared with a patient or relative. But it can also be seen as a process that takes place before, during and after bad news is broken. Thus "breaking bad news" can include a variety of news viewed as negative and in the interviews in this research "bad news" is not precisely defined, but it can include anything that the interviewed nurses view as bad news.

Permission was asked to conduct the research from the hospital district and from the selected health care centre. After permission was given, an invitation letter (see Appendix 1.) for the interview and the research plan that gave information about the research, its' aims and the confidentiality of the interviews, were sent to the health care centre to the head of the ward services. After that the head of the ward services relayed the information to the ward managers who were asked if they knew suitable or voluntary nurses for the interview.

Only one voluntary nurse for the interview was found using this method. The other nurse for the interview was found by convenience sampling from another health care centre. There isn't any rule about the amount of interviews needed for qualitative research. The aim of qualitative research is usually to understand some phenomenon, not trying to look for statistical interrelations. This makes it possible that sample size doesn't necessarily have to be large; sometimes a single case is enough. (Saaranen-Kauppinen & Puusniekka 2006.)

According to Lindlof and Taylor (2011) anyone recruited for a study should participate on a voluntary basis and they should be told that they can leave the interview at any time. Before the interview, the consent of the potential participants was asked verbally and in writing (Appendix 2.). Also the interviewees were informed the purpose and aim of the study, and explained how the research data will be used. The questions were sent beforehand to the participants, this gave the nurses time to familiarize with the subject and questions. An appointment for interview was arranged, which suited the convenience of the interviewee.

4.4 Data collection

Individual semi-structured interviews were conducted among selected nurses. One-to-one interviews were conducted with the chosen participants, because in-depth interviews are optimal for collecting data on individuals' personal histories, perspectives, and experiences (Qualitative research in nursing 2013). Semi-structured interview in this study did include both predetermined questions and open questions. Semi-structured interviews can have some pre-set questions, but allow more scope for open-ended answers (Pratt 2006). During the interview, some additional questions were made to clarify the answers

and gain additional information. The data collection was conducted in September in the year 2015.

Before the interviews, personal information; age and how many years the interviewee had worked as a nurse were asked. This information was collected to help analyzing the data. The length of each interview was approximately 30 minutes, depending on the response of the participant. The interviews were audio taped and were later written into transcripts. According to Hirsjärvi and Hurme (2011) tape recording allows the interview to be speedy and without disturbing breaks. Tape recording also preserves the conversation's important details. The interviewees will soon forget about the recorder even if they would be nervous about it in the beginning. Also it would be good to manage without making notes so that the interview would be as free and natural as possible.

Still some notes were taken during the interviews of this study. According to Hannan (2007) notes can be made to indicate additional information or points to follow up and it can save time when transcribing by listening for bits that already have been identified as important.

Before starting the interview it is good to write the name of the interviewee and the possible case number in the tape or speak them to the recorder. Also before the interview one should mention about the tape recording to the interviewee and ask if she will agree to the interview being recorded. (Hirsjärvi & Hurme 2011.) The participants were informed about the data handling process, like why it is necessary to record the interview and they were told how long the recorded data is kept and how it is protected. The interviewees were informed that all information will be kept strictly confidential and any identity will not be disclosed.

4.5 Data analysis

The inductive content analysis was used to analyze the study. Qualitative content analysis is a method that may be used with either qualitative or quantitative data and in an inductive or deductive way. Deductive content analysis is useful if the aim is to test a previous theory in a different situation or to compare categories at different time periods, so it is used when the structure of analysis is done on the basis of previous knowledge. (Elo & Kyngäs 2008.)

Inductive content analysis is used in cases where there are no previous studies dealing with the phenomenon or when it is fragmented (Elo & Kyngäs 2008). The purposes for using an inductive approach are to condense raw textual data into a brief, summary format; establish clear links between the evaluation or research objectives and the summary findings derived from the raw data. Also it is used to develop a framework of the underlying structure of experiences or processes that are evident in the raw data. Inductive approach provides procedures for analyzing qualitative data that can produce reliable and valid findings. So it provides a simple, straightforward approach for deriving findings from the focused evaluation questions. (Thomas 2006.)

Audio taped data was transcribed and the transcripts were read. The author read the transcripts many times and wrote them word to word carefully to avoid inaccuracy and misunderstanding. Every statement was analyzed for content. Some quotes were highlighted in the text if they served a special importance in the study or answered the study question. Quotes were grouped according to topics (theme coding). The main themes were derived from the research question and also sub themes related to the research was used. Main themes in this study were “surroundings”, “what is the best way of delivering bad news to the patients and to the next of kin” and “education concerning breaking bad news”. Sub themes were “frequency of breaking bad news”,

"nurses' role", "participants in breaking bad news", "phone calls to the next of kin", "does breaking bad news gets any easier with time" and "support from colleagues". Parts of data that go together under the same theme were summarized together and common patterns in quotes were searched. The responses that didn't relate to the themes or sub themes were excluded from the study.

5 Results

5.1 Breaking bad news

Interviewees in this study have worked as a nurse about twenty years and were working in a health care centre's ward. They had experience in breaking bad news to patients and their next of kin; they described that they had to break bad news quite frequently. The results of this study indicate that nurses have to break serious bad news only once a month or less often, even only as often as three to four times a year. But smaller issues like delaying discharge or transfer to central hospital due to worsening of illness, happens every week.

When talked generally about breaking bad news the nurses in this study felt that breaking bad news isn't just a single event but a series of discussions that takes place during the illness.

> *But diagnostic issues are for the doctor to tell, we as nurses are not allowed to tell about diagnostic issues. So the issues that we talk about are related to the treatment. My role is also to be between the doctor and the next of kin and clarify to them doctors, sometimes impalpable, texts.*

She also felt that breaking bad news is two people interacting and they both influence the situation.

5.2 Surroundings and participants

When asked what was in the interviewee's opinion the best way to break bad news, the interviewees first described the surroundings related breaking bad news and who should be present at that time. Also was emphasized that the discussion should take place in quiet surroundings so that others cannot hear the conversation, and usually these kinds of patients are already placed in single person rooms. If the discussion doesn't happen in the patient's room, then it should take place in some other place without any disturbances. Nurses in this study felt that a private place would also give the patient courage to talk about the situation.

Nurses in this study emphasized that it is important to make time for the discussion so that you are not in a hurry. It may not always be easy during the busy work-day:

> *Sometimes it is challenging to make the time, but then the whole care team must take the situation into account and come to help, give time and a chance for the discussion to happen. If time is not given at that time, it can be much more difficult later on to discuss about it, so it is important to give time when the situation is in hand.*

Nurses in this study thought that it would be good that next of kin would also be present during the discussion if the patient wants them there. It would be good that the doctor would also be present, because the patient can ask ques-

tions that a nurse cannot answer. And sometimes it is good to have two nurses present:

> *One nurse isn't enough if the patient is keen, aggressive or something like that. So there must be two nurses so that the other one can be a witness in case of difficult situation so that if the patient will complain, demands clarification or something like that.*

She also stated that if the patient has pain, it should first be alleviated before the discussion. A nurse should also take care of the patient's condition otherwise so that the patient's physical condition isn't difficult during the discussion. This is especially important if the discussion is long.

5.3 Breaking bad news to patients and next of kin

When discussing how to break bad news, the nurses in this study felt that it would be better to let the patients first to ask about their situation. Also, it would be important to find out what the patient knows about the situation; what and how much has already been told to him and how much he even wants to know about it. And every time of breaking bad news is different and you just have to adjust to the situation.

> *When you talk with the patient, talk calmly – don't give it straight, but approach the subject softly. And sometimes it doesn't matter what and how you try to break bad news. Each patient reacts differently to bad news, there are some patients that can't take any information, everything you say will sound like scolding to them, so nothing you do is good.*

Nurses in this study thought it is important to give the patient time during the discussion, so he has time to think and ask questions. You just have to sense how much the patient is ready to hear. And you should tell only a little at a time, because the patient usually can't absorb a lot of information at a time.

> *The patient must be taken into account as a whole. For example, if the patient has difficulty in speaking – especially then you have to give time to the patient to speak. Or if the patient is deaf or blind, you have to approach the situation from the patient's starting point. If the patient is almost unconscious we will still confront him as he was fully conscious. Even if a person cannot anymore talk or express emotions, we can never know how much he understands. He has to be treated as human being until the end.*

According to the nurses in this study, a nurse can ease a patient's anxiety by emphasizing that the patient will be taken care of and pain medication will be given, so that there will be minimum amount of pain or preferably no pain at all as the illness progresses. Also, many times the next of kin and the patient want to know how much time he has left:

> *You can never tell that, just say that we cannot predict that and we should just take one day at a time. If the patient has an incurable disease that will lead to death, you don't have to say it straight out loud if the patient doesn't seem to want to hear it.*

The nurses also felt that one should always leave room for hope. The results of the interviews suggest that each nurse must draw their own line on how close to patient's pain they can go without burning themselves out. And as a nurse you are also permitted to be moved by a patient's death.

When asked about breaking bad news to the patient's next of kin, the nurses in this study felt that if the patient hasn't been long in the ward, the condolences shouldn't be superabundant. Also the next of kin shouldn't be left alone to deal with the situation, but they should be given space to be alone with the deceased, if needed. Nurses felt that many times it is more challenging to break bad news to the next of kin than to the patient, because the next of kin often vent their anger and sadness to the attending nurse:

> *Many times you have to think what to say so that they [next of kin] don't get upset and make it feel even harder for them. Death can arouse conflicting feelings and criticism may be targeted to the nursing staff. They are just easing for their own sorrow, we cannot take it personally.*

Sometimes nurses have to notify the death of their beloved one to the next of kin by the phone. Nurses in this study felt that it is a difficult situation and demands a lot from the nurse as well, because as a nurse, one has to confront their sorrow as well. The next of kin should be notified as soon as possible after the death and one should do it in a quiet place:

> *If you start to make the phone call in the office there are a lot of people walking around and many may not even know that someone has died and that you are there to phone the next of kin about it. Someone may be joking and laughing and that is embarrassing. You have to listen to the next of kin, what questions they have and sometimes just listen them cry, just be there for them.*

The nurses in this study felt that breaking bad news doesn't necessarily get any easier even with experience. But experience can help, so that after a work day one doesn't think about difficult things that happened during the day as they used to do when they were younger nurses.

5.4 Support and education concerning breaking bad news

Nurses in this study emphasized that they get support from colleagues in breaking bad news and it is important to be able to share the difficult things that have happened during the day. Difficult situations are sometimes discussed also in staff-meetings, where they can also try to draw common lines so that everyone would act the same way in that kind of situation.

When asked if there have been other sources of information than colleagues, the nurses told that sometimes they find good articles from nursing magazines, like Tehy and Sairaanhoitajalehti, or from other literature. In these sources the subject may not always be directly discussed but some hints of breaking bad news may be given. Nurses felt that own experiences about the illness of a close one can also teach about breaking bad news.

When asked how an experienced nurse could guide a young nurse who has difficulties in breaking bad news, the following advise was given:

> *When breaking bad news you should just be yourself, the patient will sense if you will try to be something else than you are. I feel that it is best just to be as a person to another person. Treat as you would be liked to be treated in similar situation.*

The nurses in this study felt that one can support young nurses also just by saying that you can do it and you have the courage to do it.

The nurses in this study told that only a little or no education concerning breaking bad news had been provided to them. Though, some palliative education had been provided. The nurses felt that to some people breaking bad news just comes more naturally and mostly one learns it just by working. At

the end of the interview the interviewees had an opportunity to tell their opinion on what kind of education could be arranged to nurses related to breaking bad news.

> *Courses that teach interaction would be good. Interaction is not like everyone could do it – it has to be learnt so that you can get better with it. So education about how to communicate with patients and what kind of language can be used, how to respond to patient's aggressiveness and if the patient starts to complain or is depressed or anything like that. So education about how a nurse will respond to that would be good.*

So, nurses in this study thought that education concerning breaking bad news would be important.

6 Discussion

Warnock (2014) states, that the ways in which individual nurses are involved in breaking bad news is influenced by many factors, including their role and work settings. According to nurses in this study, nurses can talk about treatment related issues but shouldn't talk about diagnostic issues and sometimes they have to clarify to the patient what the doctor has said. Hietanen (2012) states that many patients have told that they didn't really hear anything what the doctor said after the first blow. So nurses play a role in breaking bad news by providing information and helping patients prepare for, receive, understand and cope with the bad news they have been given (Warnock 2014).

Nurses in this study described that they had to break bad news quite frequently. Often breaking bad news concerns smaller issues, like delaying dis-

charge or transfer to central hospital due to worsening of illness. Warnock et al. (2010) study about the frequency of breaking bad news activities among nurses showed that the most frequent were giving patients and relatives support and opportunities to talk after they had received bad news. The least frequent activity was breaking bad news to a patient or relative.

According to the nurses in this study, breaking bad news is always two people interacting, where they both influence the situation. And according to Potilasohjauksen haasteet [Challenges of patient counselling] (2006) interaction is continuous reciprocity, in which each party is at the same time an active player. There is no interaction if only one has the opportunity to talk or otherwise affect the discussion. And in all interaction there is always present both the nurses' and patients' attitudes and personalities.

Nurses in this research felt that breaking bad news should happen as soon as possible. There is no benefit to the patient or the professional to delay giving unpleasant news (Breaking bad news 2013). It is appropriate that the breaking of bad news will be as close as possible to the diagnosis (Rassin et al. 2006). In this study the nurses felt that breaking news is a series of discussions that takes place during the illness, not a single event. Rassin et al. (2006) have stated that breaking bad news is more of a process than a single action, because the patient needs time to develop awareness to the situation and internalize the news.

In this research nurses felt it would be good to find quiet place for the discussion. And according to Baile and others (2000) and Warnock (2014) a part of setting up the interview is to arrange private place for the discussion where interruptions will be minimized. According to Potilasohjauksen haasteet [Challenges of patient counselling] (2006) environmental factors can affect the interaction by supporting or weakening it. But an active presence and counsel-

ling skills of the nurse allow a successful discussion to take place, despite of distractions. Room lighting, appropriate temperature and furniture placement contributes to a positive atmosphere. Also the distance between the patient and the nurse is good to be only about half a meter.

The results of this research indicate that it is important to make time for the discussion so that you are not in a hurry. Today's shorter treatment times and rush create challenges for interaction. The importance of communication skills is emphasized in the time of hurry, because in a short period of time a nurse should be able to build a confidential counselling relationship. (Potilasohjauksen haasteet [Challenges of patient counselling] 2006). A hurried manner could have a disastrous outcome (Narayanan et al. 2010). If the breaking bad news is done badly it can influence the patient's experience and satisfaction with treatment as well as relationships with the healthcare team (Warnock 2014). There should be enough time and opportunity to devote time also to the discussion with the next of kin as it is a part of nurses' job and a lack of time can't be reason for inadequate counselling. (Potilasohjauksen haasteet [Challenges of patient counselling] 2006.)

Nurses in this study felt that it would be good that next of kin are also present during the discussion. For example Baile and others (2000) recommend asking if the patient wants to have family members to come with them to the discussion. They can provide support, hear what is said and are able to share the burden of telling others the news (Warnock 2014). But sometimes, according to Breaking bad news (2013), it might be appropriate to see family members separately if you suspect that they have different levels of knowledge or are approaching the situation very differently because differences in understanding can lead to tensions and conflict. It is important that the staff members know what has already been communicated with family members and thus the contents of discussions should be documented (Pohjois-Pohjanmaan

sairaanhoitopiirin hoitoeettinen työryhmä [Northern Ostrobothnia Hospital Care Ethics Working Group] 2010).

The nurses in this study suggested that patients' pain should be first alleviated and also to take care of the patient's condition before breaking bad news. The most commonly used methods of breaking bad news like SPIKES and BREAKS don't give advice about this, but the researcher of this study recommends it should be also mentioned when teaching breaking bad news.

In breaking bad news, the nurses of this study felt that it would be important first to find out what the patient knows about the situation; what and how much has already been told and how much he even wants to know about it. And it is recommended in literature that in the beginning of the discussion you ask how much the patient wants to know about his situation (Back & Arnold 2006, Baile et al. 2000, Narayanan et al. 2010). Back and Arnold (2006) give the following advice in assessing patient's willingness to receive information. For example you can ask "How much do you want to know about the likely course of this illness?" Or, "Some people want lots of details, some want the big picture and others prefer that I talk to their family. What would be best for you?" Some patients can say that they want a lot of information, but their body language contradicts this. A patient who says "yes" but is hesitating, looks down, shifts in his seat, or looks distressed may also be saying "no" nonverbally. You can ask "I notice you are hesitating…are you having other thoughts about this?" Or, "Is this a difficult issue for you to talk about?"

The nurses in this study advised that when talking to patients one should talk calmly and approach the subject softly. Also many times you have to think what to say so that the next of kin won't get upset and make it feel even harder for them. As Caillier (2010) says poor verbal and non-verbal communication can lead to patients feeling dissatisfied, angry and abandoned. If done

well, the process can have a beneficial effect on the ability of patients and next of kin to cope with the consequences of the illness (Warnock 2014). Also Burgers, Beukeboom and Sparks (2012) study highlights the importance of effective delivery of bad news. It showed that the way one breaks bad news have psychosocial effects on patients and seemingly harmless linguistic variations in bad news delivery can significantly affect the way the patients view on living with the disease and also to medical adherence intentions.

The nurses in this study felt that sometimes it doesn't matter what and how you try to break bad news, because to some patients everything you say will sound like you are scolding them. Hietanen (2012) states that after a difficult discussion the patient can't leave with good mood, even if we would convey our news with the language of angels. But we can affect what kind of memory the patient will have about the meeting. If we succeed well, the patient will cope better with future uncertainties.

According to the nurses in this study it is important to give the patient time to think and ask questions. The patient can handle bad news if he understands what it means to his life and body, mostly he just expects that he is listened to and told clearly enough what is happening (Paul 2013). Narayanan et al. (2010) recommend also that one must give adequate space to the patient so that emotions can freely flow.

The interviewees in this study felt that when breaking bad news, nurses should tell only a little at a time, because the patient usually can't absorb a lot of information at a time. Eggly, Penner, Albrecht, Cline, Foster, Naughton, Peterson, and Ruckdeschel (2006) suggest that giving information and probing if the patient has understood it, should be repeated with each piece of information, with clear transitions between pieces of information, and most importantly, with the relationships between pieces of information clearly ex-

plained. This ensures that patients and companions have the opportunity to absorb each piece of information, to understand the relationship between the pieces of information, and to respond with questions or comments.

So during the discussion nurses should check whether the patient heard the message that you intended to convey (Back & Arnold 2006, Baile et al. 2000, Narayanan et al. 2010). Patients and family members often misinterpret complex medical information, either hearing only the bad or good aspects of the message. You might ask, "Do you want to keep talking about this?" Or, "Am I giving you the kind of information you wanted?" Or, at the end of a conversation, "Have you have received the information you need?" (Back & Arnold 2006.)

According to the nurses of this study it is also important to give hope to the patients, as was also stated, for example, by Hietanen (2012) and Kirk et al. (2004). According to Kirk et al. (2004) room for hope has to be left to patients and families even in the patient's end stages. One can offer hope and encouragement for example by explaining about the treatment options that are available (Warnock 2014). Sometimes the patients also want to know how much time they have left. Nurses in this study felt that one should never predict it and should just encourage the patients to take one day at a time. And as Narayanan et al. (2010) state, that absolute certainty about it cannot be given to the patient.

In this study the nurses felt that it is many times challenging to break bad news to the next of kin, because they often vent their criticism, anger and sadness to the attending nurse. And for example, informing the family members about the sudden death of their loved one is a highly stressful experience; one needs a special skill in breaking the bad news to the family (Naik 2013). One of the main difficulties caregivers face is how to react to emotions that might

include anger, sorrow, anxiety, and so on (Rassin et al. 2006). But one shouldn't be afraid of emotions, you can learn how to deal with them (Seppänen 2012).

According to the nurses in this study, notifying the next of kin by phone is also demanding and should happen in a quiet place. And as Potilasohjauksen haasteet [Challenges of patient counselling] (2006) states, an effective interaction during phone-discussions requires that a nurse is aware of his own voice of tone and what words he uses during a telephone counselling. Telephone counselling is ineffective if the nurse sounds busy, rude or uninterested.

According Warnock et al. (2010) problems can arouse when the patient or relative has for example an aggressive or abusive response to bad news, or behaves in a way that prevents the nurses from giving information or care as they would wish. Also barriers in implementing effective communication about the end of life can be: personal discomfort with death and dying, lack of experience and training and mentorship, patients and/or families being reluctant to talk about the end of life, language barriers and patients young age. (Granek, Krzyzanowska, Tozer, & Mazzotta 2013.)

In this study the nurses felt that sometimes it is important just to listen to the patients or next of kin. An important part of emotional support is empathy, listening and attention to the individual and sometimes just the presence and silence are better ways than talking (Potilasohjauksen haasteet [Challenges of patient counselling] 2006). Also the nurses in this study felt that a nurse should confront the patients and next of kin as another human being. This notion is also supported by literature, for example Potilasohjauksen haasteet [Challenges of patient counselling] 2006. They suggest that simple questions such as "How are you holding up?" give a feeling of being cared for.

The nurse in this research felt that breaking bad news is a challenging task that doesn't necessarily get any easier even with experience, even though experience can help it. Becoming more skilled in communication lessens stress and burnout when breaking bad news (Caillier 2010). Also the nurses in this study thought that every nurse must draw their own line how close to patient's pain they can go without burning themselves out. According to Warnock (2014) individual practitioners should pay attention to looking after themselves and find effective ways of coping with the stressful consequences that can follow involvement in breaking bad news.

Nurses in this research emphasized that they get support from colleagues in breaking bad news and sometimes the situations are talked about in staff meetings. Also, managers should be aware that breaking bad news is demanding, time consuming and can have an impact on the emotional wellbeing of the staff (Warnock 2014). According to Breaking bad news (2013) health care professionals require secure mentoring and support so that staff feels they can accomplish the task of breaking bad news with confidence and competence. Support may involve both informal and formal debriefing, clinical supervision, specific training and a learning culture which promotes self care and reflection. The nurses in this study commented that in staff meetings they try to draw common lines, so that everyone would act the same way when breaking bad news. According to Pohjois-Pohjanmaan sairaanhoitopiirin hoitoeettinen työryhmä [Northern Ostrobothnia Hospital Care Ethics Working Group] (2010) the goals and common treatment lines should be documented systematically and make sure that everyone participating the patient's treatment are talking and acting in the same manner. If possible, meetings among the next of kin and the whole care team should be arranged.

The nurses in this study recommended that nurses, who are uncertain about breaking bad news, just to be them selves and treat the patients or next of kin

as you would like to be treated in a similar situation. Breaking bad news is an important clinical skill and following an established protocol while integrating empathetic communication makes this difficult task more comfortable for the nurses and helps to improve the communication between the patient and family (Rosenzweig 2012).

The results of this study indicate that education concerning breaking bad news has been provided in small extent and such education would be important. There has been little research about the role of the nurse in the process of breaking bad news in the inpatient clinical setting and little formal education or support for this work had been received (Warnock et al. 2010). Education would be important since nurses often have an important role in shaping patient's experiences of receiving and coping with bad news (Warnock 2014), as they are often the key professionals after "bad news" is shared (Malloy, Virani, Kelly, & Munévar 2010).

In this research the nurses felt that interaction courses that teach how to communicate with patients would be important, because interaction is not something than everyone can do; it has to be learnt. And according to Potilasohjauksen haasteet [Challenges of patient counselling] (2006) interpersonal skills are not a self-evident attribute to a nurse, but training is required. Malloy et al. (2010) state, nurses are the primary and constant healthcare providers in clinical settings, thus effective skills in communication are critical to nursing practice and to ensure quality care. Education regarding communication skills is needed in nursing education programs but also in continuing education for practicing nurses. Also, for example interactive theatre can be a potentially powerful tool to teach breaking bad news (Skye, Wagenschutz, Steiger, & Kumagai 2014). Though according to Potilasohjauksen haasteet [Challenges of patient counselling] (2006) the development of interpersonal skills does not, however, require training days outside the work unit. Profes-

sional interaction can be learned through practice, being aware of ones' own attitudes and, if necessary, amending them.

7 Ethical Considerations

7.1 General principles

Qualitative research is an exploration of the perspectives and life of human beings and the meanings they give to their experiences. In health care settings qualitative studies are generally used when the focus is on the feelings, experience and thoughts, change and conflict. Health researchers are ethically bound to act in the interests of the participants. (Holloway & Wheeler 2010.) Ethics in research includes appropriateness of the research design, the quality of the research plan and that the reporting of data is well done (Tuomi & Sarajärvi 2009). Ethics should be considered throughout the research, including data collection, analysis and presentation of findings (Rogers 2008).

In this study, the formal application for the research was pre–submitted to the hospital district and to the health care centre; in witch the aim and the procedure of the study was explained. Before the data collection, the participants were given a written form that covered the aim, expectation and procedure of the research. It also stated that all data is handled with anonymity and confidentiality. The participants had an opportunity to ask any questions to clarify what they have been told and read, before they signed the consent form. After that the participants also signed a written consent form that ensures that participation was strictly voluntary.

Ethical considerations are fundamental in ensuring that the interview procedure is safe for those who are participating. An interview may arouse buried feelings of guilt and distress, thus it is imperative that interviewer considers what effect the interview has on the research participant. (Rogers 2008.) This study focuses on participants' personal experiences in disclosing topics that are perceived as hard to talk about. The interviews gave an opportunity for participants to discuss their problems and concerns. The participants were informed that if they agreed to participate they had the right to withdraw from the study at any time. Also the participants were told before the interview that they can stop and withdraw from the interview any time if they feel the interview causes them discomfort. Rogers (2008) states that in the case of participants' distress the interviewer should ask whether the participant wish to continue, change to another topic or terminate the interview. The participant may feel obliged to carry on despite the distress. Counselling services can be suggested if the research process evokes difficult emotions.

In qualitative research, textual data is usually redacted to protect informants' identities from being revealed and other data are disguised or only used with the permission of the subjects concerned. The main strategy for preserving confidentiality is through making personal information anonymous contained in data sets. (Heaton 2004.) All records from the research study will remain confidential by the following means: all records of the research was kept confidential and the participants were given a code that is only known by the researcher; in the final report nothing was written that could in any way identify particular participants; all information, including recorded tapes of interviews, was kept in the holding of the researcher and was destroyed at the end of the research project at the end of the year 2015.

7.2 Objectivity, Integrity and Credibility

The objectivity, integrity and credibility and of this study will be provided with different methods. All data from interviews was handled similarly; this will help to achieve the objectivity of the research. Research integrity may be defined as active adherence to the ethical principles and professional standards essential for the responsible practice of research (Korenman 2006). Integrity was achieved by taking ethical considerations into account by confidentiality, anonymity and similar treatment of the participants and the results.

The credibility criteria involve establishing that the results of qualitative research are credible or believable from the perspective of the participants in the research (Trochim 2006). Patton (2015) states that the credibility of a qualitative study depends for example, on systematic fieldwork that yields high quality data, systematic data analysis and sampling methods. Selecting the most appropriate method for data collection is important in establishing credibility (Graneheim & Lundman 2003). In this study, credibility was achieved by audio taping the personal interviews. According to Lindlof and Taylor (2011) tape recording increases the accuracy of data collection, because it captures and preserves all of the interview discourse. Credibility of research findings also deals with how well categories and themes cover data, that is, no relevant data have been inadvertently or systematically excluded or irrelevant data included (Graneheim & Lundman 2003). In this study this was ensured by the careful collection and examination of the collected data. Also the data was divided under appropriate themes. According to Graneheim and Lundman (2003) critical in achieving credibility is to select the most suitable meaning unit. Too broad meaning units, for example, several paragraphs long, can be difficult to manage since they are likely to contain various meanings.

The author of this study wrote the recorded raw material carefully and transcripts were reviewed for several times so that no valuable data was lost. The same research questions were provided to the participants and all the data was handled similarly. These methods guarantee that the information is collected and processed the same way. All the processes and methods used in this study is described accurately and in detail, thus the research can be repeated in other health care surroundings by other researchers.

8 Conclusions

This study gave a nurse's point of view in breaking bad news to a patient or next of kin in two health care centres in Central Finland. The results indicate that nurses experience breaking bad news as a challenging task and breaking bad news to the patient's next of kin can be even more challenging than breaking bad news to patients. From these interviewees' answers we can also conclude that it doesn't necessarily get any easier even with experience and time. Also nurses experience that colleagues support is a significant resource in breaking bad news. Pain alleviation before breaking bad news was also seen as important. It is not commonly taught in breaking bad news literature, but the researcher in this study recommends it would be an important point in preparing to breaking bad news. As the results indicate that it is also important to give hope and not to give estimation about life expectancy to patients and next of kin, but encourage living one day at the time.

Here are summarized some main points derived from the literature and from the results from this study to aid a health care worker in delivering bad news. One can also use the checklists done in Finnish and English that summarizes "Breaking bad news" -guidance from literature (Appendix 3.). They can make

it easier to deliver bad news as they provide some points to be considered or act as a reminder on how to break bad news. They are meant to be used as a tool in patient encounters for health care workers.

There isn't any right or wrong way to break bad news; you can develop your own way that suits your personality. You can for example find new ways to handle difficult communication situations by discussing and comparing practices with colleagues. Another way is to think how and what would you yourself want to hear in a similar situation. Breaking bad news should happen as soon as possible and it would be good that next of kin were present during the discussion if the patient wants them to be there. If communicating with the patient is difficult, it might be good that two nurses are present. Alleviate pain and make the patient's physical condition comfortable before the discussion. Choose a peaceful place where you will not be interrupted and make enough time for the discussion.

You can use a template such as the SPIKES or BREAKS protocols for breaking bad news if you are unsure of how to proceed. You can also practice speaking phrases in advance. Know the patient's medical facts before initiating the conversation. Sit down, it relaxes the patient and is a sign that you are not in a hurry. Inform the patient of any time constraints you may have. Maintain eye contact during the discussion.

Use language that the patient understands. Also it is important to use participatory and encouraging sentences. Find out what the patient knows about the situation; what and how much has already been told to him and how much he even wants to know about it. Say one warning sentence, for example: "Unfortunately, I've got some bad news to tell you." Give information in small pieces and check periodically if the patient understands what has been said. Do not give any unrealistic treatment options.

Give the patient time to express his feelings and let the patient know that you understand why he is upset by making empathic response; for example "I wish the news were better." You can touch the patient's arm or hold a hand, but only if he is comfortable with this. Also you can give hope by reassuring that the best possible treatment and continuity of care is given. At the end of the discussion it is important to go through once more what was discussed.

The results of this study indicate that little education concerning breaking bad news have been provided for nurses, but such education would be important and desired. As nurses are responsible of talking about bad news in Finland, it is recommended that they should be trained in order to perform the task effectively. Without skills in breaking bad news there might be miss-communication and misunderstandings between patients and nurses. Errors in communication can cause harm to the patient's mental well-being. Thus nurses should have the appropriate knowledge and skills to deliver upsetting information as clearly as possible and also in a caring manner. Also, the researcher thinks that all nursing staff should have at their disposal standard protocols to ensure that breaking bad news is done professionally.

It is recommended that further in-depth studies should be conducted among nurses in order to identify the issues related to the breaking of bad news. The research could be implemented for nurses in a larger scale in various working environments. In this research the participants already had experiences about breaking bad news. Future research could also include nurses who have had less experience of breaking bad news. This would provide information about the relatively inexperienced nurses' capabilities of breaking bad news, what they perceive as the most difficult aspect in it, and how it differs from the perspective of more experienced nurses. Since there were only two participants in this study, broader results concerning whole Central Finland area were im-

possible to achieve. Future research could be also implemented in different parts of Finland to see if the results differ geographically.

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9 Appendices

9.1 Appendix 1. Invitation for the interview

HEI!

Etsin kahta sairaanhoitajaa haastateltavaksi opinnäytetyötäni varten.
Olen sairaanhoitajaopiskelija Jyväskylän ammattikorkeakoulusta (JAMK), englanninkielisestä Nursing-koulutusohjelmasta. Olen tekemässä opinnäytetyötä aiheesta ”Kuinka kertoa vaikea asia potilaalle tai hänen läheisilleen”. Opinnäytetyön tavoitteena on tarjota tietoa, joka voisi auttaa sairaanhoitajia välittämään vaikeita uutisia. Lisäksi tavoitteena on kartoittaa kuinka sairaanhoitajia voitaisiin tukea vaikeiden uutisten välittämisessä.

Haastattelu kestäisi noin tunnin. Haastattelu on täysin vapaaehtoinen ja teillä on milloin tahansa, myös haastattelun aikana, mahdollista lopettaa haastattelu ja vetäytyä pois projektista. Kaikki haastattelujen aikana tulleet asiat ovat täysin luottamuksellisia eikä niitä luovuteta eteenpäin. Tietoja käsitellään alusta alkaen kirjalliseen tuotokseen asti sellaisella tavalla ettei haastateltavan henkilöllisyys missään vaiheessa paljastu muille ja pysyy vain haastattelijan tiedossa. Toivoisin toteuttavani haastattelut tänä syksynä syys-lokakuun aikana. Tämän opinnäytetyön tuloksena (pohjautuen sekä kirjallisuuteen että haastatteluihin) teen posterin englanniksi ja suomeksi, jossa tiivistetysti ohjataan kuinka vaikeasta asiasta voisi puhua potilaan ja hänen läheistensä kanssa niin, että tilanne olisi mahdollisimman miellyttävä molemmille osapuolille, sekä kertojalle että kerrottavalle. Posterit luovutettaisiin käyttöönne opinnäytetyön valmistumisen jälkeen ja uskon niistä voivan olla apua henkilökunnallenne erilaisissa potilas-tilanteissa.

Terveisin:
Marika Kolehmainen

9.2 Appendix 2. Consent form for interview

SUOSTUMUS HAASTATTELUUN

OPINNÄYTETYÖN NIMI:

Breaking bad news to patients and next of kin (vaikeiden uutisten kertominen potilaille ja heidän läheisilleen)

Haastattelua käytetään kartoittamaan sairaanhoitajien kokemuksia vaikeiden asioiden kertomisesta.

Osallistuminen on vapaaehtoista. Tutkimuksen tiedot käsitellään

luottamuksellisesti, eikä yksilöiviä tietoja julkaista.

Suostun osallistumaan opinnäytetyöhön:

_____

Haastateltavan allekirjoitus ja nimenselvennys

Opinnäytetyön tekijän allekirjoitus ja nimenselvennys:

Paikka ja aika:

_____ ___/___ _____

9.3 Appendix 3. Checklists

BREAKING BAD NEWS

Preparation

- Think what you will say and how to respond to patient's emotional reactions
- Make sure the patient is as comfortable as possible
- Arrange some privacy for the meeting or for phone call
- Ask if the patient wants to have a next of kin present. If there are several family members, ask the patient to choose one or two family representatives
- Ensure you have adequate time for the discussion
- Sit down; it relaxes the patient and shows that you are not in a hurry. Inform the patient of any time constraints you may have or interruptions you expect
- Maintain eye contact

Give information

- Ask how the patient perceives the medical situation, what has already been told and how much the patient wants to know
- Say one warning sentence, for example: "Unfortunately I've got some bad news to tell you"
- Use simple language and avoid medical terms and excessive bluntness e.g., "You have very bad cancer and unless you get treatment immediately you are going to die" or, "There is nothing more we can do for you"
- Give information in small pieces at a time and check periodically if the patient understands what has been said
- Check that the patient did not misunderstand the nature or the realistic course of the disease, or the gravity of the situation
- Do not give absolute certainties about how much time they have left or unrealistic treatment options

Respond to emotional reactions and give support

- Ask what the patient is thinking or feeling
- Give the patient time to express his feelings
- Let the patient know that you understand why he is upset by saying for example:
- "I know that this isn't what you wanted to hear." Or, "I wish the news were better"
- If patient doesn't calm down, say for example "I can tell you weren't expecting to hear this"
- You can touch the patients' arm, but only if he is comfortable with it
- If emotions are not clearly expressed, such as when the patient is silent, you can ask
- for example "Could you tell me what you're worried about?"
- If patient is disappointed or angry, like "I guess this means I'll have to suffer through
- chemotherapy again" you can still use an empathic response "I can see that this is upsetting
- news for you"
- You can show support to the patient by saying for example "I can understand how you felt
- that way." Or, "I guess anyone might have that same reaction in your situation"
- You can give hope by reassuring that the best possible treatment and continuity of care are given

Summary

Summarize the session and the concerns expressed by the patient during the session

References: Baile, W.F., Buckman R., Lenzi, R., Glober, G., Beale, E.A. & Kudelka, A. P. 2000. *SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer.*
Narayanan, V., Bista, B. & Koshny, C. 2010. *'BREAKS' protocol for breaking bad news.*

VAIKEAN ASIAN KERTOMINEN

Esivalmistelut

- Mieti mitä aiot sanoa ja kuinka vastaat potilaan tunnereaktioihin
- Varmista, että potilaan fyysinen olotila on mahdollisimman hyvä
- Varaa keskustelulle tai puhelinkeskustelulle rauhallinen paikka
- Kysy haluaako potilas läheisiään mukaan keskusteluun. Jos läheisiä on useita, niin pyydä potilasta valitsemaan yksi tai kaksi edustajaa
- Varaa keskustelulle riittävästi aikaa
- Istu alas; se rauhoittaa potilasta ja kertoo siitä ettet ole kiireinen. Ilmoita potilaalle mahdollisista aikarajoitteista tai keskeytyksistä
- Ylläpidä katsekontaktia

Anna tietoa

- Kysy miten potilas kokee oman tilanteensa, mitä on jo kerrottu ja kuinka paljon hän haluaa tietää
- Sano yksi varoittava lause kuten ”Ikävä kyllä minulla on huonoja uutisia”
- Käytä yksinkertaista kieltä, vältä lääketieteellisiä termejä ja ylenpalttista suorasukaisuutta, kuten ”Sinulla on hyvin paha syöpä ja ellet saa hoito heti niin kuolet” tai ”Emme voi tehdä avuksesi enää mitään”
- Anna tietoa pienissä osissa kerrallaan ja tarkista välillä, että potilas on ymmärtänyt asian
- Tarkista, että potilas ei ole ymmärtänyt väärin sairauden laatua ja etenemistä tai tilanteen vakavuutta
- Älä anna tarkkoja ennusteita elinajasta tai epärealistisia hoitovaihtoehtoja

Vastaa tunnereaktioihin ja anna tukea

- Kysy mitä potilas ajattelee ja tuntee
- Anna potilaalle aikaa ilmaista tunteensa
- Osoita, että ymmärrät miksi potilas on masentunut esimerkiksi sanomalla “Tiedän, että tämä ei ollut sitä mitä halusit kuulla” tai ”Toivoin, että uutiset olisivat olleet parempia”
- Jos potilas ei rauhoitu, sano esimerkiksi ”Huomaan ettet ollut valmistautunut kuulemaan tätä”
- Voit koskettaa potilaan kättä, mutta vain jos se on potilaasta luontevaa
- Jos potilas ei osoita tunteitaan selvästi, hän on esimerkiksi hiljaa, voit kysyä esimerkiksi ”Voitko kertoa mikä huolestuttaa sinua?”
- Jos potilas reagoi pettymyksellä tai vihalla esim. ”Tämä kai tarkoittaa, että minun täytyy kärsiä taas kemoterapiasta” voit silti lähestyä empaattisesti: ”Huomaan, että tämä on masentava uutinen sinulle.”
- Voit osoittaa tukea potilaalle sanomalla esimerkiksi ”Ymmärrän miksi sinusta tuntuu tuolta” tai ”Uskoisin, että kuka tahansa tuntisi samoin tilanteessasi”
- Voit antaa toivoa vakuuttamalla, että potilas saa parasta mahdollista hoitoa ja että hoito jatkuu

Loppuyhteenveto

Käy läpi mitä on puhuttu ja mitä huolia potilaalle keskustelun aikana nousi mieleen

Lähteet: Baile, W.F., Buckman R., Lenzi, R., Glober, G., Beale, E.A. & Kudelka, A. P. 2000. *SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer.* Narayanan, V., Bista, B. & Koshny, C. 2010. *‘BREAKS’ protocol for breaking bad news.*